

		FOR OHF USE					

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**2004**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2004)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0040683</u></p> <p><b>Facility Name:</b> <u>Alden Long Grove Rehab &amp; HC Ctr</u></p> <p><b>Address:</b> <u>Box 2308, RFD Hicks Road</u> <u>Long Grove</u> <u>60047</u>          Number City Zip Code</p> <p><b>County:</b> <u>Lake</u></p> <p><b>Telephone Number:</b> <u>(773) 286-3883</u> <b>Fax #</b> <u>(773) 286-3743</u></p> <p><b>IDPA ID Number:</b> <u>36-4003486</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>03/01/95</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven M. Kroll</u> <b>Telephone Number:</b> <u>(773) 286-3883</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Steven M. Kroll</u></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p style="text-align: center;"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>Steven M. Kroll</u>		(Title) <u>Chief Financial Officer</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr# 0040683 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>248</u>	Skilled (SNF)	<u>248</u>	<u>90,768</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>248</u>	TOTALS	<u>248</u>	<u>90,768</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,448</u>	<u>2,323</u>	<u>6,556</u>	<u>15,327</u>	8
9	SNF/PED					9
10	ICF	<u>35,160</u>	<u>996</u>	<u>320</u>	<u>36,476</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>41,608</u>	<u>3,319</u>	<u>6,876</u>	<u>51,803</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 57.07%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)day care

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started

3/1/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 3/1/95NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified

95

and days of care provided

6,180Medicare Intermediary Administar Federal, Inc.

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.



## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr # 0040683 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	313,537	40,878	9,600	364,015	833	364,848		364,848		1
2	Food Purchase		306,272		306,272	(27,401)	278,871	(12,147)	266,724		2
3	Housekeeping	209,040	44,009		253,049	436	253,485		253,485		3
4	Laundry	36,595	18,343		54,938	273	55,211		55,211		4
5	Heat and Other Utilities			162,762	162,762		162,762	(332)	162,430		5
6	Maintenance	33,842	867	215,102	249,811	231	250,042	9,932	259,974		6
7	Other (specify):* Related Party Salary							38,310	38,310		7
8	<b>TOTAL General Services</b>	593,014	410,369	387,464	1,390,847	(25,628)	1,365,219	35,763	1,400,982		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			83,500	83,500		83,500		83,500		9
10	Nursing and Medical Records	2,810,039	197,716	24,108	3,031,863		3,031,863	(139,660)	2,892,203		10
10a	Therapy	50,862			50,862	3,532	54,394		54,394		10a
11	Activities	57,950	2,393		60,343	92	60,435		60,435		11
12	Social Services	22,949		7,381	30,330		30,330		30,330		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Salary							28,648	28,648		15
16	<b>TOTAL Health Care and Programs</b>	2,941,800	200,109	114,989	3,256,898	3,624	3,260,522	(111,012)	3,149,510		16
	<b>C. General Administration</b>										
17	Administrative	54,159			54,159		54,159		54,159		17
18	Directors Fees										18
19	Professional Services			680,752	680,752		680,752	(596,776)	83,976		19
20	Dues, Fees, Subscriptions & Promotions			47,686	47,686		47,686	(35,334)	12,352		20
21	Clerical & General Office Expenses	252,283	21,273	64,047	337,603	201	337,804	(47,883)	289,921		21
22	Employee Benefits & Payroll Taxes			464,465	464,465	21,803	486,268	(14,928)	471,340		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,448	6,448		6,448	12,370	18,818		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			230,705	230,705		230,705	274	230,979		26
27	Other (specify):* Related Party Salary			162,752	162,752		162,752	190,253	353,005		27
28	<b>TOTAL General Administration</b>	306,442	21,273	1,656,855	1,984,570	22,004	2,006,574	(492,024)	1,514,550		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,841,256	631,751	2,159,308	6,632,315		6,632,315	(567,273)	6,065,042		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.



## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

#0040683

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			198,485	198,485		198,485	421	198,906			30
31	Amortization of Pre-Op. & Org.							1,640	1,640			31
32	Interest			491,404	491,404		491,404	(435,508)	55,896			32
33	Real Estate Taxes			109,899	109,899		109,899	7,294	117,193			33
34	Rent-Facility & Grounds			1,894,150	1,894,150		1,894,150		1,894,150			34
35	Rent-Equipment & Vehicles			11,720	11,720		11,720	20,764	32,484			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,705,658	2,705,658		2,705,658	(405,389)	2,300,269			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	15,882	525,812	723,960	1,265,654		1,265,654	(27,632)	1,238,022			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,152	136,152		136,152		136,152			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	15,882	525,812	860,112	1,401,806		1,401,806	(27,632)	1,374,174			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,857,138	1,157,563	5,725,078	10,739,779		10,739,779	(1,000,294)	9,739,485			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.



Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,222)	30		9
10	Interest and Other Investment Income	(311)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,099)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(14,044)	21		17
18	Fines and Penalties	(15,300)	32		18
19	Entertainment	(8,609)	20		19
20	Contributions	(2,296)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,819)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(162,752)	27		24
25	Fund Raising, Advertising and Promotional	(20,853)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(299)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (240,604)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(145,939)	Various	34
35	Other- Attach Schedule	(613,751)	Pg 5A	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (759,690)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,000,294)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47



Alden Long Grove Rehab & HC Ctr

ID# 0040683

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Back out 31.78% of PAC fees from standard IHCA b	(3,775)	20 1
2	Late fees on utilities	(2,451)	5 2
3	Intercompany Interest (GL7031 less Therapeutic)	(469,524)	32 3
4	Back out credit related to prior year (GL7143-Vendor Sett	(489)	21 4
5	Rent & Commissions (GL4977)	(246)	21 5
6	Medical Records (GL4977)	(94)	21 6
7	Wage Service Fee (GL4977)	(10)	22 7
8	Interest (GL4977)	(30)	32 8
9	Personal Telephone (GL4977)	(720)	5 9
10	Marketing Manager (GL 6701-100-009)	(123,888)	21 10
11	Back out % of Employee Benefits for Marketin Manager	(14,918)	22 11
12	Depreciation on Deferred Maintenance "Painting" (Pg 22)	2,293	6 12
13	Adjust depreciation expense for prior years	101	30 13
14			14
15			15
16			16
17			17
18			18
19			19
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40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(613,751)	49



## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,099)	0	0	(11,048)	0	0	0	0	0	0	0	(12,147)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,171)	0	2,839	0	0	0	0	0	0	0	0	(332)	5
6	Maintenance	2,293	0	8,480	0	0	0	(65)	(776)	0	0	0	9,932	6
7	Other (specify):*	0	0	38,310	0	0	0	0	0	0	0	0	38,310	7
8	<b>TOTAL General Services</b>	<b>(1,977)</b>	<b>0</b>	<b>49,629</b>	<b>(11,048)</b>	<b>0</b>	<b>0</b>	<b>(65)</b>	<b>(776)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>35,763</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(132,049)	(7,611)	0	0	0	0	0	0	(139,660)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	28,648	0	0	0	0	0	0	0	0	28,648	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>28,648</b>	<b>(132,049)</b>	<b>(7,611)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(111,012)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,819)	0	(591,957)	0	0	0	0	0	0	0	0	(596,776)	19
20	Fees, Subscriptions & Promotions	(35,832)	0	498	0	0	0	0	0	0	0	0	(35,334)	20
21	Clerical & General Office Expenses	(138,761)	0	32,144	51,494	7,240	0	0	0	0	0	0	(47,883)	21
22	Employee Benefits & Payroll Taxes	(14,928)	0	0	0	0	0	0	0	0	0	0	(14,928)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	12,370	0	0	0	0	0	0	0	0	12,370	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	274	0	0	0	0	0	0	0	0	274	26
27	Other (specify):*	(162,752)	0	329,705	12,079	11,221	0	0	0	0	0	0	190,253	27
28	<b>TOTAL General Administration</b>	<b>(357,092)</b>	<b>0</b>	<b>(216,966)</b>	<b>63,573</b>	<b>18,461</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(492,024)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(359,069)</b>	<b>0</b>	<b>(138,689)</b>	<b>(79,524)</b>	<b>10,850</b>	<b>0</b>	<b>(65)</b>	<b>(776)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(567,273)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(10,121)	0	9,144	0	1,398	0	0	0	0	0	0	421 30
31	Amortization of Pre-Op. & Org.	0	0	1,640	0	0	0	0	0	0	0	0	1,640 31
32	Interest	(485,165)	0	46,529	0	519	2,609	0	0	0	0	0	(435,508) 32
33	Real Estate Taxes	0	0	6,801	0	493	0	0	0	0	0	0	7,294 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	20,764	0	0	0	0	0	0	0	0	20,764 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(495,286)</b>	<b>0</b>	<b>84,878</b>	<b>0</b>	<b>2,410</b>	<b>2,609</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(405,389) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(26,998)	(37,341)	36,707	0	0	0	0	0	(27,632) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(26,998)</b>	<b>(37,341)</b>	<b>36,707</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(27,632) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(854,355)</b>	<b>0</b>	<b>(53,811)</b>	<b>(106,522)</b>	<b>(24,081)</b>	<b>39,316</b>	<b>(65)</b>	<b>(776)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,000,294) 45</b>



Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 professional fees	\$ 602,005	Alden Management Services		\$	\$ (602,005) 15
16	V	19 professional fees		Alden Management Services		10,048	10,048 16
17	V	21 gen'l & admin		Alden Management Services		32,144	32,144 17
18	V	5 utilities		Alden Management Services		2,839	2,839 18
19	V	6 maintenance		Alden Management Services		8,480	8,480 19
20	V	24 travel & seminar		Alden Management Services		12,370	12,370 20
21	V	26 insurance		Alden Management Services		274	274 21
22	V	20 dues & subscriptions		Alden Management Services		498	498 22
23	V	30 depreciation		Alden Management Services		9,144	9,144 23
24	V	31 amortization		Alden Management Services		1,640	1,640 24
25	V	33 real estate tax		Alden Management Services		6,801	6,801 25
26	V						
27	V	35 rent-equip & vehicles		Alden Management Services		20,764	20,764 27
28	V	32 interest		Alden Management Services		46,529	46,529 28
29	V	7 salaries - gen'l serv		Alden Management Services		38,310	38,310 29
30	V	15 salaries - health care		Alden Management Services		28,648	28,648 30
31	V	27 salaries - gen'l admin		Alden Management Services		329,705	329,705 31
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 602,005			\$ 548,194	\$ * (53,811) 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Tube Feeding	\$ 43,793	Pyramid Health Care Services	100.00%	\$ 32,745	\$ (11,048)	15
16	V	10 Nursing Supply	138,510	Pyramid Health Care Services		6,461	(132,049)	16
17	V	39 Per diems/other supplies	61,360	Pyramid Health Care Services		34,362	(26,998)	17
18	V	21 General & admin		Pyramid Health Care Services		51,494	51,494	18
19	V	27 General & admin Salaries		Pyramid Health Care Services		12,079	12,079	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 243,663			\$ 137,141	\$ * (106,522)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Drugs	\$ 172,036	Forum Extended Care II	100.00%	\$ 148,388	\$ (23,648)	15
16	V	10 House Stock	4,794	Forum Extended Care II		4,135	(659)	16
17	V	39 IV	99,611	Forum Extended Care II		85,918	(13,693)	17
18	V							18
19	V	21 G & A		Forum Extended Care II		7,240	7,240	19
20	V	32 Interest		Forum Extended Care II		519	519	20
21	V	33 Real Estate taxes		Forum Extended Care II		493	493	21
22	V	30 Depreciation		Forum Extended Care II		1,398	1,398	22
23	V	27 General & admin Salaries		Forum Extended Care II		11,221	11,221	23
24	V	10 Pharmacy Consulting	6,952	Forum Extended Care II			(6,952)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 283,393			\$ 259,312	\$ * (24,081)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Therapy	\$ 707,690	Community Physical Therapy	100.00%	\$ 744,397	\$ 36,707	15
16	V	32 Interest		Community Physical Therapy		2,609	2,609	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 707,690			\$ 747,006	\$ * 39,316	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS & MAINTENANCE	\$ 44,786	ALDEN BENNETT CONSTRUCTION		\$ 44,721	\$ (65)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 44,786			\$ 44,721	\$ * (65)

\* Total must agree with the amount recorded on line 34 of Schedule VI.



Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 CARPET CLEANING	\$ 3,015	ALDEN REALTY - CARPET CARE		\$ 2,698	\$ (317)	15
16	V	6 FLOOR CLEANING	4,710	ALDEN REALTY - FLOOR CARE		4,251	(459)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 7,725			\$ 6,949	\$ * (776)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



## STATE OF ILLINOIS

Page 6K

Facility Name &amp; ID Number ALDEN NURSING CENTER - Long Grove

# 004-0683

Report Period Beginning 01/01/04

Ending: 12/31/04

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Lincoln Park	Chicago
ANC Heather	Harvey
ANC Waterford	Aurora
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomington
Alden of Old Town West	Bloomington
Alden Trails	Bloomington
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governors' Park	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living



## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	100.00	217,421	1.816	4.54	salary	\$ 10,343	27-7	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	70,209	1.816	4.54	salary	3,340	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	47,729	1.816	4.54	salary	2,825	7-7	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	\$ 16,508		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION



Facility Name & ID Number Alden Long Grove Rehab & HC Ctr # 0040683 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W Peterson Ave.  
 City / State / Zip Code Chicago, IL 60646  
 Phone Number ( 773 ) 286-3883  
 Fax Number ( 773 ) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	see page 8A (also on page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25



**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Therapeutic Systems		x	working capital			\$	\$			\$	6,580	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	related party-ams & other	x		working capital								46,529	6	
7	related party-cpt/bus loan	x		working capital								2,609	7	
8	related party-fecII	x		working capital								519	8	
9	TOTAL Facility Related						\$	\$				\$	56,237	9
	B. Non-Facility Related*													
10	offset interest expense with interest income (GL4964,4983,4646)											(341)	10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	\$				\$	(341)	14
15	TOTALS (line 9+line14)						\$	\$				\$	55,896	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)



## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Alden Long Grove Rehab & HC Ctr    COUNTY    Lake

FACILITY IDPH LICENSE NUMBER    0040683

CONTACT PERSON REGARDING THIS REPORT    Steven M. Kroll

TELEPHONE    (773) 286-3883    FAX #:    (773) 286-3743

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-08-419-040-0000</u>	<u>Nursing Home Facility</u>	\$ <u>107,599</u>	\$ <u>107,599</u>
2.    _____	<u>Related Party - Alden Management</u>	\$ <u>149,765</u>	\$ <u>6,801</u>
3.    _____	<u>Related Party - Forum</u>	\$ <u>13,827</u>	\$ <u>493</u>
4.    _____	_____	\$ _____	\$ _____
5.    _____	_____	\$ _____	\$ _____
6.    _____	_____	\$ _____	\$ _____
7.    _____	_____	\$ _____	\$ _____
8.    _____	_____	\$ _____	\$ _____
9.    _____	_____	\$ _____	\$ _____
10.    _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>271,191.00</u>	\$ <u>114,893.00</u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    \_\_\_\_\_ YES    x \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.



X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
89,632

B. General Construction Type:

Exterior
brick

Frame
steel

Number of Stories
2

C.
Does the Operating Entity?

☐ (a) Own the Facility
☐ (b) Rent from a Related Organization.
☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☐ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3



Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		Related party-Forum		1978	\$ 16,213	\$	22	\$	\$	\$ 16,213	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		SHELVING		1995	5,122	256	20	256		2,497	9
10		ROOF REPAIR		1995	3,000	300	10	300		2,900	10
11		STEAMER REPAIR		1995	2,686	269	10	269		2,596	11
12		EXIT DOOR-FIRE		1995	4,225	282	15	282		2,652	12
13		REPAIR BOILER/HVAC-MAJ.REP.		1995	4,712		5			4,712	13
14		PIPE/VALVE/THERMOSTAT		1996	1,460	73	20	73		675	14
15		ELECTRICAL REPAIR/INSTALLATION		1996	2,110	106	20	106		941	15
16		SIGN		1996	7,233		5			7,233	16
17		WATER HEATER ON DISHWASHER		1996	7,464	746	10	746		6,469	17
18		WALLGUARD		1996	2,096	140	15	140		1,188	18
19		INSTALL BOILER-MAJ.REP.		1996	33,750	1,688	20	1,688		14,203	19
20		REPLACE CONDENSOR WALK IN COOLER		1996	5,514	551	10	551		4,641	20
21		INSTALL ALUM. LOGO		1996	1,995	166	12	166		1,538	21
22		DESIGN SERVICE		1996	8,100	405	20	405		3,341	22
23		WASHROOM IMPROVEMENTS		1996	2,186	109	20	109		911	23
24		PIPING-MAJ.REP.		1996	4,000	267	15	267		2,156	24
25		PIPING-MAJ.REP.		1996	3,500	233	15	233		1,925	25
26		ATASH(replaced heat detector&fire dampers)		1997	959		5			959	26
27		ATASH(installed access panels)		1997	924		5			924	27
28		ATASH( fire alarm repairs)		1997	2,212		5			2,212	28
29		CLIMATE(installation of water heaters)		1997	7,342		5			7,342	29
30		CLIMATE(replced hydro.boiler)		1997	4,568		5			4,568	30
31		Wally's flooring(install new tiles).		1997	2,659		5			2,659	31
32		ATASH(SPRINKLER WORK)INV.#9120&9121		1997	3,072		5			3,072	32
33		ATASH(SPRINKLER WORKS)		1997	2,062		5			2,062	33
34		Climate srvc( two water heater)		1997	15,600		5			15,600	34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Wigdahl(install light fixtures)	1997	\$ 7,207	\$	5	\$	\$	\$ 7,207		37
38	Wigdahl(install light fixtures)	1997	6,204		5			6,204		38
39	Climate(install compressor)	1997	6,750		5			6,750		39
40	Star contractor(door frame)	1997	2,973		5			2,973		40
41	Wally's flooring(install new tiles).	1997	2,659		5			2,659		41
42	Climate svcs(new pipe and air vents)	1997	6,354		5			6,354		42
43	EQUIPMENT INT'L LTD. (labor, parts, assembly)	1997	2,542		5			2,542		43
44	DOOR	1997	3,109	311	10	311		2,409		44
45	INSTALL NEW DROP CEILING	1997	2,175	181	12	181		1,405		45
46	DESIGN SERVICES	1997	931	47	20	47		369		46
47	NEW DRIVEWAY LIGHTING	1998	8,101	540	15	540		3,736		47
48	REPLACE WASHING MACHINE MOTORS	1998	1,752		5			1,752		48
49	REPLACE BOILER	1998	4,253	212	20	212		1,467		49
50	REPAIR PUMP MOTOR	1998	3,312		5			3,312		50
51	REPAIR DRYERS	1998	2,534	253	10	253		1,731		51
52	REPAIR EMERGENCY CIRCUITS	1998	1,510	151	10	151		1,032		52
53	REPAIR EMERGENCY LIGHTING SYSTEM	1998	273	27	10	27		187		53
54	REPLAC E COMPRESSOR	1998	1,301	130	10	130		889		54
55	REPLACE SEAVES ON ROOF	1998	10,500	700	15	700		4,492		55
56	REPLACE HOT WATER HEATER	1998	2,200	220	10	220		1,430		56
57	REPAIR GENERATOR	1998	5,228	349	15	349		2,207		57
58	REPLACE BEARING IN WASHER	1998	1,296	65	20	65		416		58
59	PATTEN-REPAIR GENERATOR	1998	655	33	20	33		210		59
60	D.B.S. Contracting(sprinkler system installation)	1999	32,838	1,314	25	1,314		7,772		60
61	D.B.S. Contracting(sleeve pipeline for sprinkler system)	1999	5,720	572	10	572		3,384		61
62										62
63	Climate Service (pipework for boiler and storage tank)	1999	2,032	102	5	102		2,032		63
64	D.B.S. Contracting (need invoice)	1999	3,425	343	10	343		1,912		64
65	Chicago Cooling (repair pump)	1999	2,482	207	5	207		2,482		65
66	AMC Building Material	1999	4,131	454	10	413	(41)	2,478		66
67	AMC Sprinklers	1999	3,853	424	10	385	(39)	2,310		67
68	System Electric(generator repair)	1999	2,720	272	10	272		1,428		68
69	Patten Industries(install starter)	1999	5,495	550	10	550		2,885		69
70	TOTAL (lines 4 thru 69)		\$ 301,278	\$ 13,045		\$ 12,966	\$ (80)	\$ 204,604		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 301,278	\$ 13,045		\$ 12,966	\$ (80)	\$ 204,604	1
2	AMC Building Material	1999	1,876	206	10	188	(19)	1,128	2
3	Fox Valley(sprinkler repair)	1999	1,803	120	15	120		621	3
4	Alden Bennet Cons.install tank)	1999	6,281	628	10	628		3,193	4
5	Alden Bennet Cons.(repair wind damage)	1999	34,195	1,368	25	1,368		6,953	5
6	AMC Security system	1999	7,273	727	10	727		3,697	6
7	AMC carpentry	1999	8,577	943	10	858	(86)	5,148	7
8	Climate Service (repair HVAC)	1999	9,358	936	10	936		4,757	8
9	ABC-construction mainten. Adjustment-various	1999	1,129	409	10	113	(296)	678	9
10	Climate services (A/C REPAIR)	2000	2,482	496	5	496		2,482	10
11									11
12	B&L Locksmith (knob set)	2000	3,750	250	15	250		1,208	12
13	Alden Bennett Construction (major repairs)	2000	1,628	358	5	326	(33)	1,628	13
14	D.B.S. Contracting (repair lawn sprikler system)	2000	1,635	327	5	327		1,472	14
15	D.B.S. Contracting (repair lawn sprikler system)	2000	2,285	457	5	457		2,057	15
16	Alden Bennett Construction (major repairs)	2000	2,643	291	10	264	(27)	1,320	16
17	Alden Bennett Construction (time & material billing per fac)	2000	2,105	231	10	211	(21)	1,055	17
18	alden design-architectural/designing	2000	2,628	131	20	131		580	18
19	alden design-architectural/designing	2000	3,300	165	20	165		729	19
20	ABC-time & materials-maj. Leasehold improv-various	2000	1,918	141	15	128	(13)	640	20
21									21
22	Patten industries 1137844(major repair for electric starting motor)	2001	4,103	410	10	410		1,641	22
23	Alden bennett construction (drive way improvement)	2001	1,096	80	15	73	(7)	292	23
24	T & T irrigation ( lawn sprinkler system)	2001	2,064	206	10	206		671	24
25	Alden bennett construction	2001	9,690	1,066	10	969	(97)	3,876	25
26	New horizons commu1884(installation hardware phone)	2001	1,986	199	10	199		778	26
27	ABC-Pond, parking lot, and site improvements related to these	2001	642,434	27,718	25	25,697	(2,021)	102,788	27
28	Alden Bennett Constr.-Roof repairs	2002	1,856	408	5	371	(37)	1,113	28
29	CSI-Coker	2002	2,502	500	5	500		1,460	29
30	Alden Bennett Constr.-Misc repairs	2002	1,628	626	5	326	(301)	978	30
31	Valley Fire Protection Systems (replace fire sprinkler pipes)	2003	9,000	900	10	900		1,800	31
32	Capps Plumbing & Sewer (Pump For Sprinkler System)	2003	4,324	865	5	865		1,730	32
33	Alden Bennett Constr (Misc. repairs)	2003	5,417	1,192	5	1,083	(108)	2,166	33
34	TOTAL (lines 1 thru 33)		\$ 1,082,244	\$ 55,402		\$ 52,258	\$ (3,144)	\$ 363,240	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,082,244	\$ 55,402		\$ 52,258	\$ (3,144)	\$ 363,240	1
2	The Floor Source (Alden Design)(2nd flr-corridor carpet/public spa)	2003	22,250	2,781	8	2,781		4,404	2
3	The Floor Source (Alden Design)(carpet-corridor attic stock)	2003	4,289	858	5	858		1,215	3
4	C I Service (Alden Design) (2nd floor-corridor window treatments)	2003	12,949	1,619	8	1,619		2,159	4
5	Reagal Mirror & Art (resident room art tackboards)	2003	5,675	709	8	709		946	5
6									6
7	Controlled Irrigation (repair sprinkler system)	2003	2,137	427	5	427		570	7
8	Alden Bennett Constr (sink,drain,faucetsprinkler system)	2003	17,025	1,873	10	1,703	(170)	3,406	8
9	A & B Custom Cable (cable installation)	2003	3,100	310	10	310		388	9
10	Alden Bennett Constr (roof repairs)	2003	12,754	1,403	10	1,275	(128)	2,550	10
11	ALDEN BENNETT CONSTRUCTION (FILE CABINET,NURSE)	2003	3,927	288	15	262	(26)	524	11
12	C I SERVICE(ALDEN DESIGN)(BEDSPREADS,DRAPERIES)	2003	23,920	2,990	8	2,990		4,485	12
13	A&B CUSTOM CABLE (CABLE INSTALLATION)	2003	2,495	250	10	250		374	13
14	ALDEN BENNETT CONSTRUCTION (2ND FLOOR REMODEL	2003	243,207	30,401	8	30,401		45,601	14
15	ALDEN BENNETT CONSTRUCTION (BULLETIN BOARDS,PU	2003	6,175	710	10	618	(93)	1,236	15
16	HENRICKSEN (ALDEN DESIGN)(SECOND FLOOR RESIDENT	2003	33,234	4,154	8	4,154		5,539	16
17	HENRICKSEN (ALDEN DESIGN)(SECOND FLOOR PUB SPAC	2003	20,151	2,519	8	2,519		3,149	17
18	ALDEN BENNETT CONSTRUCTION (2ND FLOOR REMODEL	2003	46,393	9,821	8	5,799	(4,022)	11,598	18
19	ALDEN BENNETT CONSTRUCTION (2ND FLOOR REMODEL	2003	188,477	25,871	8	23,560	(2,311)	47,120	19
20	ALDEN BENNETT CONSTRUCTION (DOOR)	2003	4,065	407	10	407		644	20
21									21
22	Equipment International (replace bearings in washer)	1998	1,738	116	15	116		715	22
23									23
24	Graphic Systems (remodelled second floor Signage)	2004	2,519	231	10	231		231	24
25	Alden Bennett Const (toilets, sheet metal work for oxygen tank)	2004	6,569	462	15	438	(24)	438	25
26	CSI Coker -I Walkin cooler replacement	2004	2,980	596	5	596		596	26
27	GT Mechanical (Circ Pump-Doctors' room leaking)	2004	1,667	28	15	28		28	27
28	GT Mechanical (Cooling for Electric Suction Room)	2004	6,325	105	10	105		105	28
29	GT Mechanical (Rooftop,Boiler and Exhaust fan repairs)	2004	4,681	39	20	39		39	29
30	CSI Coker (Dishwasher, Steamer repairs)	2004	2,431	41	10	41		41	30
31	GT Mechanical (Repairs-electric feeds-RTU's-2nd floor roof)	2004	6,077	25	20	25		25	31
32	CSI Coker (Dishwasher, Steamer repairs)	2004	1,566	13	10	13		13	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,771,020	\$ 144,448		\$ 134,530	\$ (9,917)	\$ 501,378	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page I2C, Carried Forward		\$ 1,771,020	\$ 144,448		\$ 134,530	\$ (9,917)	\$ 501,378	1
2	ALDEN BENNETT CONSTRUCTION (2ND FLOOR REMODEL	2004	(22,058)	(2,527)	8	(2,527)		(2,527)	2
3	TNS Inc. (DSL cable)	2004	1,725	316	5	316		316	3
4	ALDEN BENNETT CONSTRUCTION (Unit 30 remodelling) recla	2004	13,902	2,228	8	1,738	(491)	1,738	4
5	HENRICKSEN (ALDEN DESIGN)(SECOND FLOOR RESIDENT	2004	(33,234)	(5,539)	8	(5,539)		(5,539)	5
6	HENRICKSEN (ALDEN DESIGN)(SECOND FLOOR PUB SPAC	2004	(20,151)	(3,149)	8	(3,149)		(3,149)	6
7	ALDEN BENNETT CONSTRUCTION (5 toilets bowl/tank new sy	2004	2,301	132	20	115	(17)	115	7
8	ALDEN BENNETT CONSTRUCTION (5 toilets bowl/tank new sy	2004	878	51	20	44	(7)	44	8
9	ALDEN BENNETT CONSTRUCTION (FENCING, FLOORING, S	2004	15,285	1,318	10	1,529	210	1,529	9
10	NEW HORIZONS COMMUNIC-INCREASE CAPACITY OF PH	2004	3,755	344	10	344		344	10
11	NEW HORIZONS COMMUNIC-INCREASE CAPACITY OF PH	2004	7,160	656	10	656		656	11
12	NEW HORIZONS COMMUNIC-INCREASE CAPACITY OF PH	2004	969	89	10	89		89	12
13	BROLIN LOCK & SAFE (REPLACE LOWER LEVEL LOCKS/K	2004	5,512	551	10	551		551	13
14	ALDEN BENNETT CONSTRUCTION (West side-Permanent Ligh	2004	3,541	118	20	118		118	14
15	C I SERVICE(ALDEN DESIGN)(BEDSPREADS,DRAPERIES)	2004	24,107	2,762	8	2,762		2,762	15
16	ALDEN BENNETT CONSTRUCTION (GT Mechanical-Generato	2004	10,656	142	25	142		142	16
17	ALDEN BENNETT CONSTRUCTION (Central States-Sprinkler S	2004	13,017	347	25	347		347	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,798,386	\$ 142,289		\$ 132,067	\$ (10,222)	\$ 498,915	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,798,386	\$ 142,289		\$ 132,067	\$ (10,222)	\$ 498,915	1
2	Related Party-Forum:								2
3	Leasehold Improvement-Remodeling	1980	12,303		15			12,303	3
4	Leasehold Improvement-Remodeling	1980	19,273		20			19,273	4
5	Leasehold Improvement-Tenant Improvement	1987	996		13			996	5
6	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	6
7	Leasehold Improvement-Roof	1994	3,572	223	16	223		2,234	7
8	Leasehold Improvement-Build.Improv.	1996	1,259	79	16	79		704	8
9	Leasehold Improvement-Asphalting	2000	98		3			98	9
10	Leasehold Improvement-DAI	2001	172	17	10	17		54	10
11	Leasehold Improvement-Bathrooms	2002	733	82	7	82		181	11
12	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		328	12
13	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,820	148	7	148		148	13
14	Leasehold Improvement-Add-on Improvement, fixture base	1980	79		23			79	14
15	Leasehold Improvement-Add-on Improvement, lighting base	2001	137	27	5	27		103	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	Related Party-AMS:								25
26	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	26
27	Leasehold Improvement-Remodeling	2002	4,861	608	7	608		1,215	27
28	Leasehold Improvement-Remodeling	2003	5,085	775	7	775		1,394	28
29									29
30									30
31									31
32	Forum Extended Care, LLC-building/building improv	1999	13,393	266	30	266		2,041	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,884,082	\$ 144,677		\$ 134,455	\$ (10,222)	\$ 560,344	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 353,649	\$ 40,257	\$ 40,257	\$	Various	\$ 163,012	71
72	Current Year Purchases	167,961	20,645	20,645		Various	20,645	72
73	Fully Depreciated Assets	84,745	3,419	3,419		Various	84,745	73
74								74
75	TOTALS	\$ 606,355	\$ 64,321	\$ 64,321	\$		\$ 268,402	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	various/dodge	98-'04	\$ 8,164	\$ 130	\$ 130	\$	3	\$ 7,981	76
77										77
78										78
79										79
80	TOTALS			\$ 8,164	\$ 130	\$ 130	\$		\$ 7,981	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,498,601	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 209,128	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 198,906	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,222)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 836,727	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: TL Enterprises

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		248	3/1/95	\$ 1,881,301	15 years	15	3
4	Additions							4
5								5
6								6
7	TOTAL		248		\$ 1,881,301			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☒ YES ☐ NO Terms: purchase option/deposit \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 6,662 Description: Copy Machine lease \$4,814 + Postage Meter Rental \$1,848

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	transport-non-patients	various	\$ 421.50	\$ 5,058	17
18					18
19	related party-AMS	various	1,730.33	20,764	19
20					20
21	TOTAL		\$ 2,151.83	\$ 25,822	21

10. Effective dates of current rental agreement:

Beginning 3/1/95

Ending 3/1/10

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ 1,881,301

13. /2006 \$ 1,881,301

14. /2007 \$ 1,881,301

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nurses on site

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.



**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 212,928	\$		\$ 212,928	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			57,977			57,977	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			274,039			274,039	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Page 16A	# of prescripts				134,695		134,695	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1,39-3		15,882			27,881		43,763	12
13	Other (specify):	See Page 16A				36,708	477,912		514,620	13
14	TOTAL			\$ 15,882		\$ 581,652	\$ 640,488		\$ 1,238,022	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.



Page 16
Col 5: PT,OT, & ST
Col 6: Other
Amount

XIV. SPECIAL SERVICES (Direct Cost)

Service

1. OT	39-3	\$212,928.38
2. ST	39-3	57,976.87
3.		
4. PT	39-3	274,039.46
5.		
6.		
7.		
8.		
9. Pharmacy	See pg 16A	172,035.86
Plus: Related Party- Forum Drugs		(23,648.00)
Plus: Related Party- Forum I.V.		(13,693.00)
Total to line 9 Pharmacy		134,694.86
10.		
11.		
12. Exceptional Care-Column 3	See pg 16A	15,881.79
12. Exceptional Care-Column 6	See pg 16A	27,881.34
13. Other:Lab, x-ray therapy, Mattress, Pyramid billings		472,842.53
Oxygen Cost - IDPA		32,067.00
Related Party- Pyramid		(26,998.00)
Related Party- CPT		36,708.00
Total to line 13		514,619.53
14. Total		1,238,022.23



		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>200,000</u> )	2,296,680		3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,326		6
7	Other Prepaid Expenses	3,974		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from 3rd parties</u>	25,087		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,337,067	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,084,916		15
16	Equipment, at Historical Cost	501,353		16
17	Accumulated Depreciation (book methods)	(826,358)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	64,916		21
22	Other Long-Term Assets (spe <u>Purchase Options</u> )	744,000		22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,568,827	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,905,894	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,404,573	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	138,495		28
29	Short-Term Notes Payable	52,191		29
30	Accrued Salaries Payable	335,746		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,957		31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>accr ins, exps, idpa, sales tax, etc</u>	832,652		36
37	<u>Due to third parties (related parties or owi</u>	9,291,913		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 13,185,527	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	18,595		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 18,595	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 13,204,122	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (8,298,228)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,905,894	\$	48

\*(See instructions.)



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,785,347)	1
2	Restatements (describe):		2
3	external audit adjustments made after 2003 cost report was	13,766	3
4	submitted. These have no effect on prior years report :		4
5	Telephone expense		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,771,581)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(2,526,647)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (2,526,647)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (8,298,228)	24 *

\* This must agree with page 17, line 47.



**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,932,997	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,932,997	3
<b>B. Ancillary Revenue</b>			
4	Day Care	700	4
5	Other Care for Outpatients		5
6	Therapy	117,798	6
7	Oxygen	41,293	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 159,791	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,184	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,277	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,633	19
20	Radiology and X-Ray		20
21	Other Medical Services	100,509	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 109,603	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	311	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 311	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Medical Records,Wage Service Fee,Interest,Telephone	1,100	28
28a	Write off Old Amounts Due (related to prior year, not offs	9,330	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 10,430	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,213,132	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,390,847	31
32	Health Care	3,256,898	32
33	General Administration	1,984,570	33
<b>B. Capital Expense</b>			
34	Ownership	2,705,658	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,265,654	35
36	Provider Participation Fee	136,152	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,739,779	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,526,647)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,526,647)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



## STATE OF ILLINOIS

Page 20

Facility Name &amp; ID Number Alden Long Grove Rehab &amp; HC Ctr

# 0040683

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,048	2,192	\$ 88,259	\$ 40.26	1
2	Assistant Director of Nursing	1,960	2,208	80,799	36.59	2
3	Registered Nurses	34,627	36,521	1,107,319	30.32	3
4	Licensed Practical Nurses	15,368	16,140	360,879	22.36	4
5	Nurse Aides & Orderlies	79,009	83,064	974,393	11.73	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,982	2,184	31,718	14.52	8
9	Activity Director	1,744	1,766	27,037	15.31	9
10	Activity Assistants	2,968	3,154	30,913	9.80	10
11	Social Service Workers	792	830	22,950	27.65	11
12	Dietician					12
13	Food Service Supervisor	567	581	14,773	25.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,370	34,562	298,765	8.64	15
16	Dishwashers					16
17	Maintenance Workers	1,888	1,948	33,842	17.37	17
18	Housekeepers	24,163	25,573	209,040	8.17	18
19	Laundry	5,133	5,325	36,595	6.87	19
20	Administrator	922	922	54,159	58.74	20
21	Assistant Administrator					21
22	Other Administrative	8,735	9,196	223,195	24.27	22
23	Office Manager	1,766	1,862	23,419	12.58	23
24	Clerical	2,713	2,746	24,811	9.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,944	4,192	133,706	31.90	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Pro Care Mgr	112	112	4,788	42.75	32
33	Other(specify) Alzheimers Staff	5,531	5,734	75,778	13.22	33
34	TOTAL (lines 1 - 33)	228,342	240,812	\$ 3,857,138 *	\$ 16.02	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,600	1-3	35
36	Medical Director	Monthly	97,500	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,952	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	95	5,107	11-3	44
45	Social Service Consultant	20	1,074	11-3	45
46	Other(specify) Alzheimers Consultant	58	3,156	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	173	\$ 122,389		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53



## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Rosalinda Tolentino	Administrator		\$ 54,159	Workers' Compensation Insurance	\$ 72,021	IDPH License Fee	\$
				Unemployment Compensation Insurance	43,773	Advertising: Employee Recruitment	802
				FICA Taxes	283,271	Health Care Worker Background Check (Indicate # of checks performed 37 )	258
Note : additional administrator salaries				Employee Health Insurance	57,724	Surety Bond Fees	1,220
were allocated to this facility from the				Employee Meals	27,401	IL Healthcare Assoc	8,105
home office and are included on line 27.				Illinois Municipal Retirement Fund (IMRF)*		Secretary of State-Dues & Subscriptions	200
						eHealth Data,DTCPub,IL Health-Dues & Su	1,269
						related party-AMS	498
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	(
(List each licensed administrator separately.)			\$ 54,159			Non-allowable advertising	(
B. Administrative - Other						Yellow page advertising	(
Description			Amount				
			\$				
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V,	\$ 471,340	TOTAL (agree to Sch. V,	\$ 12,352
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Amount
AMS	Management Fees	\$	602,005			\$	
BDO Seidman	Accounting Fees		11,544				
Ken Fisch / Greenberg	Legal Fees		18,133				
Maple Hill	Legal Fees		698				
Medi.Com	Billing Consultants		690				
American Express Tax	Medicaid Rate Appeal Consulta		1,698				
Dart Chart Systems	Medicare Consultant		45,984				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 680,752				

\* Attach copy of IMRF notifications

**\*\*See instructions.**



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PLUMBING	9/95	\$ 2,766	3	\$	\$	\$	\$	\$	\$	\$	\$	
2	PAINTING,SMOKE DET	12/95	3,737	3-10	128	128	128	128	117				
3	PAINTING	1/96	2,369	3									
4	PAINTING	2/96	1,798	3									
5	PAINTING	3/96	1,844	3									
6	PAINTING	5/96	2,336	3	see page 22A for grand totals....								
7	PAINTING	4/96	12,094	3									
8	BOILER REPAIRS	5/96	2,100	3									
9	PAINTING	7/96	4,364	3									
10	PAINTING	6/96	2,141	3									
11	PAINTING	8/96	4,395	3									
12	PAINTING	9/96	1,606	3									
13	CHEMICAL FILTER	11/96	2,229	15	149	149	149	149	149	149	149	149	
14	PAINTING	12/96	2,331	3									
15	Install compressor(hvac)	6/97	4,125	3	0								
16	painting	6/97	35,000	3	0								
17	hvac/hot water sensor	6/97	2,322	3	0								
18	water chiller/hvac	7/97	1,800	3	0								
19	boiler controller/hvac	11/97	3,125	3	0								
20	TOTALS		\$ 92,482		\$ 277	\$ 277	\$ 277	\$ 277	\$ 266	\$ 149	\$ 149	\$ 149	



Facility Name &amp; ID Number

Alden Nursing Center - Long Grove

2004

Ending: 12/31/2004

## XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Climate Srv-repair pump	12/97	1,859	3	0								
2	Custom Appl-a/c's	1/98	2,940	3	0								
3	painting 1998	3/98	4,139	3	230	0							
4	painting 1998	6/98	5,582	3	776	0							
5	painting 1998	9/98	4,240	3	942	0							
6	painting 1998	12/98	3,014	3	921	0							
7	H.Scales-abt appliance	8/99	3,034	3	1,011	590							
8	CSI-flow switch/hvac	10/99	3,828	3	1,276	957	0						
9	Capps-sewer rodding	9/99	1,680	3	560	373	0						
10	CSI- hvac	12/99	2,482	3	827	758	0						
11	Painting>\$1,500 ytd 1999	7/99	13,288	3	4,429	2,215	0						
12	CAPPS PLUMBING (SEWAGE CLE	5/00	5,430	3	1,810	1,810	603	0					
13	VENDOR REC REVERSING		(2,482)	3									
14	GT MECHANICAL (chiller circulatin	8/00	1,523	3	508	508	296	0					
15	WRITE OFF CUST MAPP ?		(2,940)	3									
16	Alde Bennett Construction (time & m	12/00	21,314	3	7,105	7,105	6,512	0					
17	Painting>\$1,500 ytd 2000	7/00	8,699	3	2,900	2,900	1,450	0					
18	GT Mechan. (hvac repair)	2001	1,507	3	0	502	502	503	0				
19	Painting>\$1,500 for 2001	2001	2,048	3	341	683	683	341	0				
20	Sherwin Williams --Painting	1/02	9,990	3		3,330	3,330	3,330					
21	CSI -- Service Cleveland	2/02	6,313	3		579	2,104	2,104	1,526				
22	GT Mechan. (compressor-A/C)	5/04	3,119	3				693	1,040	1,040	346		
23													
24	Totals from Page 22 . . .		92,482		277	277	277	277	266	149	149	149	149
25	TOTALS	\$	193,088		23,913	22,586	15,756	7,248	2,832	1,189	495	149	149



Facility Name & ID Number Alden Long Grove Rehab & HC Ctr

STATE OF ILLINOIS

# 0040683

Report Period Beginning: 01/01/2004

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Ending: 12/31/2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. IL Healthcare Assoc. \$11,880
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,600 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 136,152  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 27,401 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: BDO Seidman, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.



Alden Nursing Center - Long Grove  
Reporting Period Beginning  
Reporting Period Ending

004-0683  
1/01/04  
12/31/04

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Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(27,401)	Employee Meal
	22	27,401	Employee Meal
22		(5,598)	Uniforms
	10	3,532	Uniforms
	6	231	Uniforms
	4	273	Uniforms
	1	833	Uniforms
	3	436	Uniforms
	11	92	Uniforms
	21	201	Uniforms
		<hr/>	
		0	Net should be 0